Certification of Health Care Provider for Family Member's Serious Health Condition
Family and Medical Leave Policy for Employees of Maine State Government

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Policy for Employees of Maine State Government (FMLPMSG) requires that an employee seeking Family Medical Leave (FML) because of a need for leave to care for a covered family member with a serious health condition submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. You may not ask the employee to provide more information than what is covered in this form. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employee's family members, created for FML purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with state and federal law and regulations.

Employer name and contact:_____

Date form provided to employee:_____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her medical provider. The FMLPMSG requires that you submit a timely, complete, and sufficient medical certification to support a request for FML leave to care for a covered family member with a serious health condition. Your response is required to obtain or retain the benefit of FMLPMSG protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FML request. You have 15 calendar days to return this form to your employer.

Your name:_____
First Middle Last

Name of family member for whom you will provide care:_____
First Middle Last

Relationship of family member to you:_____

If family member is your son or daughter, date of birth:_____

Describe care you will provide to your family member and estimate length of leave needed to provide care:

_____

_____

_____

_____ _____
Employee Signature Date

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SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLPMSG to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLPMSG coverage. Limit your responses to the condition for which the patient needs leave. Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Provider's name and business address:_____

Type of practice / Medical specialty:_____

Telephone:(___)_____Fax:(___)_____

PART A: MEDICAL FACTS

1. Approximate date condition commenced:_____

   Probable duration of condition:_____

   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

   ___No ___Yes. If so, dates of admission:_____

   _____

   Date(s) you treated the patient for condition:_____

   Was medication, other than over-the counter medication, prescribed?_____No_____Yes

   Will the patient need to have treatment visits at least twice per year due to the condition?____No____Yes

2. Is the medical condition pregnancy?___No ___Yes. If so, expected delivery date:_____

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

_____

_____

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PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation, or the provision of physical or psychological care.

4. Will the patient be incapacitated for one or more continuous periods of time, including any time for treatment and recovery? ___No ___Yes.

   Estimate the beginning and ending dates for the period of incapacity?_____

   During this time, will the patient need care? ___No ___Yes.

   Explain the care needed by the patient and why such care is medically necessary:_____

5. Will the patient require follow-up treatments, including any time for recovery? ___No ___Yes.
   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period.

   Explain the care needed by the patient, and why such care is medically necessary:_____

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?
   ___No ___Yes.

   Estimate the hours the patient needs care on an intermittent basis, if any:

   _____hour(s) per day; _____days per week from_____through_____

   Explain the care needed by the patient, and why such care is medically necessary:_____

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7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ___No ___Yes.

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):
Frequency:_____times per_____week(s)_____month(s)
Duration:_____hours or_____day(s) per episode
Does the patient need care during these flare-ups? ___No ___Yes.
Explain the care needed by the patient, and why such care is medically necessary:_____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER

Signature of Health Care Provider **Date**

PRINTED NAME AND TITLE